Rural Expansion of Afghanistan's Community-Based Healthcare Project (REACH): Quarterly Report on Gender Activities, February – April 2005

June 2005

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REACH QUARTERLY REPORT ON GENDER ACTIVITIES
FEBRUARY – APRIL, 2005

Activities related to gender undertaken during the months of February, March and April 2005 are listed under the REACH Intermediate Results (IR) to which they apply.

IR 1: Expanded access to quality BPHS services
Components:
- Expand coverage of basic essential obstetric care, child health and family planning services, & tuberculosis control through increased number of health facilities and community outreach
- Improve the capacity of health providers to provide services in rural areas and in health facilities (recruitment, training, deployment of CHWs, auxiliary midwives, health staff of referral centers)

REACH gender activities undertaken during this reporting period:

- Developed materials for the gender awareness session of the BPHS course for the Refresher Training unit (see ANNEX A).
- Provided gender orientation to participants during the CBHC work planning workshop on 10 April.

IR2: Improved capacity of individuals, families, and communities to protect their health
Component: Implement behavior change communication to promote healthful practices through public health education programs including interpersonal communication by community health workers and community midwives and through multi-media communication campaign.

REACH gender activities undertaken during this reporting period:

- In collaboration with the MOWA, the MOPH, UNFPA, JICA and the REACH IEC Unit, revised the Reproductive Health and Rights brochure originally produced by the Department of Health of the Ministry of Women's Affairs.

IR 3: Strengthened health systems
Component: Improve capacity of the MOH to plan, manage, and allocate resources, increase human capacity, strengthen the health information system, monitor and evaluate the BPHS program, make management and policy decisions based on data, and manage the essential drug supply system at national and provincial levels.

REACH gender activities undertaken during this reporting period:

- Conducted workshops for PPHCC members in three provinces to raise awareness of gender in public health programs. The three-day gender awareness training took place in Bamyan (21 to 23 February), Herat (7-9 March), and Paktya (19-21 April). A total of 67 people (24 female, 43 male; 20 governmental staff, 47 non-governmental staff) have been trained (see ANNEX B).
- Regularly participated in the weekly meetings of the Association for the Empowerment of Afghan Women Health Professionals. Representatives of the Association have petitioned the Deputy Ministers of Public Health to create a Department of

Nursing/Midwifery in the new organogram of the MOPH. The Association's constitution has been approved by the Ministry of Justice.

Other activities during this reporting period:

- Conducted in-house Gender Awareness Workshop on 15-16 February for PSI managers to raise awareness of gender in public health (see ANNEX C).
- Provided REACH gender training materials to Learning for Life, the UNFPA Regional Team and the USAID/RAMP Gender Specialist for use in their programs (Note: The Ministry of Women's Affairs has no standardized gender awareness training materials.)
- Submitted REACH Initiatives to Support Women to the REACH CTO and Gender Advisor in USAID/Washington (see ANNEX D).

Annexes:

A. Training materials developed for the session on gender in the BPHS refresher training course: Gender Awareness Participants Guide (A1), gender awareness resource, "The Impact of Gender in Public Health" (A2), Gender Awareness Trainers' Guide (A3)
B. Reports on the Gender Awareness Workshops held for PPHCC members in Bamyan (B1), Herat (B2), and Paktya (B3) provinces
C. Report on the Gender Awareness Training Workshop held for PSI
D. One page briefer: "REACH Initiatives to Support Women"
E. Profile and analysis of female participation in REACH training/workshops/meetings
F. Spread sheet profile and analysis of female participation in REACH training/workshops/meetings

Annex A1

Gender Awareness

Introduction to training
The goal of this session on gender is to increase awareness among doctors, nurses, and midwives about the issues related to cultural expectations of gender roles and how they impact on health and delivery of health care services.

This workshop session is designed to give providers a chance to "bring alive" the gender issues that permeate all cultures in order to become more sensitive to the impact of gender in health service delivery. It is hoped this training will serve as a first step in catalyzing the awareness necessary to work for change and greater gender equity; to make a better world possible for men and women.

Objectives

- Define the meaning of gender.
- Describe gender issues that effect health in your community.
- List several gender stereotypes in your culture.
- Explain possible options for addressing gender inequities in health care service delivery.
- Demonstrate the practice of gender sensitivity during health care delivery.

Organization of the Training
There are 4 exercises, plus the introductory discussion, in the training. Trainers should be equipped with a flipchart and marker pens. Each session has learning objectives, exercises (brainstorming, cases, or exercises) and approximate time length. The sessions are interactive and comprise realistic exercises that provide opportunities for gender awareness to develop.

It is important that participants take the time to carefully read the reference manual and review the participants manual ahead of time. They should be very familiar with this information before starting the day of training.

Session content
Introductory discussion (30 minutes)
Brainstorming about gender roles and stereotypes (60 minutes)
Case study: A girl's life (60 minutes)
Group work: Identify gender issues seen in the health facility and the community and find solutions. (30 minutes)
Brainstorming exercise: the ideal world: no gender inequality (30 minutes)

A. Brainstorming about gender roles and stereotypes (60 minutes)

Objective: Realize and overcome gender stereotypes and understand their meaning
Procedure: brainstorm the following activities with the whole class. The trainer will write answers on the flipchart.

1. Consider the following two phrases, "In my culture, women must… In my culture, men must …." Each will be written by the trainer on a page of the flipchart. Participants will be asked to brainstorm the responses and the trainer will write them on the flipchart.

- Discuss the activity using the following questions:
  - What are your observations in comparing these two lists? What do these lists show you?
  - How do people view the characteristics/activities on the two lists?
  - Do women and men have to be or do the things that you wrote down?
  - Can women and men do things expected of the opposite sex? What are the consequences?
  - How do these different roles, responsibilities, and expectations affect the life choices of women? Of men?

2. The definitions of sex roles and gender roles will be presented by the trainer: Sex and gender roles are activities assigned to individuals based on either sex (biological characteristics) or gender (socially determined characteristics). Think of examples of male and female gender roles from your experience. Responses will be written on the flipchart.

3. The issue of gender stereotypes will be presented: they emerge from confusion between sex roles and gender roles. When it is believed that gender roles are based on biological differences rather than socially constructed expectations, the result is gender stereotypes. Share examples of gender stereotypes. Responses will be written on the flipchart.

Women are: **Men are:**

4. The meaning of gender discrimination will be presented: the unequal or unfair treatment of men or women based solely on their sex rather than on their individual skills, talents, and capabilities. (This concept can be explained by comparing it to racial discrimination, which is more widely understood).

Identify whether each statement below demonstrates a gender role, gender stereotype, sex role, or gender discrimination. Remember that gender roles (roles that are socially constructed) are often believed to be biological and thus unchangeable. In fact, the only items among the statements that cannot change are those related to sex roles.

Statements about men and women:

1. Women give birth to babies, men do not.
2. Girls are gentle, and boys are tough.
3. Amongst Indian agricultural workers, women are paid 40-60 percent of the male wage.
4. Women can breastfeed babies; men can bottle feed babies.
5. Most building site workers in Britain are men.
6. Men are better than women at math, physics, and science.
7. In Ancient Egypt men stayed at home and did weaving while women handled family business. Women inherited property and men did not.
8. According to UN statistics women do 67 percent of the world's work, but their earnings amount to only 10 percent of the world's income.
9. Men's voices break at puberty, women's voices do not.
10. Women are soft-spoken and gentle; men are assertive and strong.
11. Men make decisions about family planning and the number of children a couple will have.

B. CASE STUDY: A GIRL'S LIFE *(60 minutes)*

Objective: Understand the meaning of gender especially in the context of health
Procedure: Participants will be divided into small groups. A volunteer in each group will read aloud the case study. Participants will brainstorm the questions below in their small groups. A volunteer should take notes and summarize the answers. After all the questions have been answered, the groups will share their answers with the whole group. The trainer will list the answers on the flipchart.

Shafiqa was born into a family of six children—four boys and two girls. She was the fourth child and the youngest girl. Her family survived by farming and selling a small amount of cash crops. Often there was not enough food to feed everybody in the family adequately. As in most families in her community, her father and brothers ate first, then she and her sister were fed, and her mother ate last. Shafiqa grew slowly, but this was considered normal.

When she was six, Shafiqa began school. But after two years, she had to stop because there wasn't enough money to send all the children to school. Her two older brothers continued, while Shafiqa and her older sister stayed home to help their mother with farming, caring for their young brothers, and other household tasks.

By the time Shafiqa was 12, the family was better off financially. They'd learned some new agricultural techniques and were selling more crops. Shafiqa wanted to return to school, but her father would not let her. The school was far away, and he was concerned about her traveling that distance. Also, there was only one male teacher at the school, and he did not find it appropriate that his daughter, who was nearing puberty, be taught by men. Besides, he explained to his wife, Shafiqa would be getting married soon—there was no need for her to go to school, and no need to risk her being spoiled before marriage. Her older sister, Suraya, who was 17, had already been married two years and had one child.

When Shafiqa was 15 she was married to Ahmad and went to live with his family. Within four months she was pregnant. By the time she was 18, she had three daughters. She was always tired, her health was poor, and she often felt isolated and depressed. Though she couldn't read, she had heard about family planning and suggested to Ahmad that they consider it so she could have a rest. Ahmad became furious and beat her. He pointed out that she had not yet provided him with a son and that family planning was unnatural, anyway. Shafiqa, feeling that she had been appropriately reprimanded for her bold and presumptuous behavior, did not bring up the subject again.

Shafiqa's health continued to deteriorate. She was treated several times at the health clinic for itchiness and discharge in her genital area. Each time, the nurses at the clinic told her that she must use condoms to prevent this sickness. They would become quite annoyed that she had not used them. But Shafiqa knew that Ahmad would refuse them. Shafiqa's fourth child was a son, and Ahmad was very pleased. He looked forward to his second and third son. Meanwhile, Shafiqa became more and more sad and tired.

1. Identify the factors that contributed to Shafiqa's poor state of physical and emotional health. Be sure to think about the cultural, social, economic, and political factors that affected Shafiqa throughout her life cycle.

- Possible factors:

2. Develop a list of different program interventions that could have been introduced at various points in Shafiqa's life that might have improved her reproductive health.

- Possible programs

3. Practical and strategic needs: The trainer will discuss with the class the concept of practical and strategic needs and identify examples of projects that address practical needs and projects that address strategic needs to ensure that participants understand the distinction.

- Practical needs: projects that address such immediate needs as health, family planning, housing, water supply, sanitation.

- Strategic needs: projects such as legislation for equal rights and opportunities for women, eliminating harmful traditional practices and violence against women, increasing women's participation in decision making, literacy, education, etc.

3a. The participants will be divided into four groups. Two of the groups will identify the practical needs of Shafiqa and the types of projects that might address these practical needs. The other two groups will identify Shafiqa's strategic needs and the types of projects that might address Shafiqa's strategic needs. Each of the groups will present their findings and the trainer will list them on the flipchart.

Practical needs:
Possible projects:

Strategic needs:
Possible projects:

3b. In the large group, the trainer will refer to the list of Shafiqa's practical needs and strategic needs. With the whole group, discuss the relationship between them.

- Which needs are most immediate?
- Which strategic needs are most essential for women's empowerment that results in real change in status and position?
- If the interventions implemented affected only Shafiqa's practical needs but not her strategic needs, what do you think the outcome would be for her? Would her life be different? In what ways? What about her children's lives?
- Why is it important to consider strategic gender issues?

C. Group work: Identify gender issues seen in the health facility and the community and find solutions. (30 minutes)

Objective: Demonstrate gender sensitive service delivery in their practical work
Procedure: The participants will be divided into small groups. Participants will identify gender issues in their own health facilities, and in their communities in way that impact health. List them. Then they should propose realistic solutions to change the situations. A volunteer should take notes and summarize the answers. The groups will share the identified gender issues and possible solutions with the whole group.

D. Brainstorming exercise: the ideal world: no gender inequality (30 minutes)

Objective: Use their new gender awareness to demonstrate/list what is possible.
Procedure: Refer back to the flipchart in the first exercise, where participants explored gender roles and expectations and completed the sentence, "In my culture, men (women) must . . . ."

The trainer will remind participants that gender differences are socially constructed and learned. Participants will be asked to close their eyes for a minute and try to imagine a world where gender inequalities no longer exist—where men and women have the same rights; the same possibilities for education, employment, and advancement; the same income-generating power; and the same decision-making power.

Participants will be divided into small groups and asked to answer the following questions. One participant should summarize the answers and share in the large group afterward.

- What would that world be like?
- What would the impact of such gender equity and equality be on the reproductive health of that society?
- How would the reproductive health roles and responsibilities within the family shift? What would those roles be like?
- Who would benefit?
- Identify ways in which the promotion of gender equity can result in positive gains for men as well as women.
- Develop strategies and approaches for involving men in reproductive health programs and promoting changes in traditional gender roles.

Annex A2

The Impact of Gender in Public Health

The definition of gender

The term gender refers to social roles that men and women play, because of the way their society is organized. Gender is expressed in the kinds of relations between sexes that arise from those roles, and in assumptions about "appropriate" behaviors. Unlike sex, which is universal, biological, and unchanging, gender roles and relationships are learned, vary among cultures (as well as among social groups within the same culture), and change over time. Gender roles may evolve through changes in education, technology, and economics, and crises like war or famine. Gender is often misunderstood to mean *women*, when, in reality, gender refers to the roles and relationships of both women and men in a given cultural context. Although gender roles limit both women and men, they generally have had a more repressive impact on women.

Gender roles

Gender roles are influenced by perceptions and expectations arising from cultural, political, environmental, economic, social, and religious factors, as well as from custom, law, class, ethnicity, and individual or institutional biases. Gender attitudes and behaviors are learned and can be changed.

Sex roles: the only roles related to sex are those associated with reproduction; for example, women give birth and breastfeed, and men impregnate women with sperm.

Gender roles: activities assigned to individuals on the basis of socially determined characteristics, such as stereotypes, ideologies, values, attitudes, beliefs, and practices. Gender roles are established through the influence of family, community, schools, religious institutions, culture/tradition/folklore/history, media, policies, peer groups, and the workplace.

- Women cook and clean the house; men earn income through paying jobs outside of the home.
- In Ancient Egypt men stayed at home and did weaving while women handled family business. Women inherited property and men did not.
- In one study of 224 cultures, there were five in which men did all the cooking and 36 in which women did all the house building.

Gender stereotypes: emerge from confusion between sex roles and gender roles. When it is believed that gender roles are based on biological differences rather than socially constructed expectations, the result is gender stereotypes. . Gender stereotypes categorize men and women according to rigid constructs and promote the belief that these differences are biological.

- Women are dependent, weak, incompetent, emotional, supporters, cooperative.
- Men are independent, powerful, competent, logical, leaders, competitive.

Gender discrimination: the unequal or unfair treatment of men or women based solely on their sex rather than on their individual skills, talents, and capabilities.

- Amongst Indian agricultural workers, women are paid 40-60 percent of the male wage.
- According to UN statistics women do 67 percent of the world's work, but their earnings amount to only 10 percent of the world's income
- Men make decisions about family planning and the number of children a couple will have.

What are some of the situations in which we see gender differences?

- Social: different perceptions of men's and women's social roles: the man is seen as head of the household and chief breadwinner, while the woman is seen as nurturer and caregiver.

- Political: differences in the ways in which women and men assume and share power and authority: men are more involved in national and higher-level politics, while women are more involved at the local level in activities linked to their domestic roles.
- Educational: differences in the educational opportunities and expectations of girls and boys: family resources are directed to boys' rather than girls' education, and girls are streamed into less-challenging academic tracks.
- Economic: differences in women's and men's access to lucrative careers and control over financial and other productive resources, such as credit, loans, and land ownership.

Gender division of labor: women's "triple role"

Women frequently have responsibilities related to their reproductive role, including childrearing and the associated tasks such as maintaining the family and household. Both women and men are involved in productive labor, which includes wage employment and production of goods. However, their functions and responsibilities differ. Women's productive work is typically less visible and lower paid than men's. In some cases, work done primarily by men becomes lower paid and less prestigious when women begin to do it, and "women's work" earns higher pay when done by men (for example, cleaning, cooking, etc.). Similarly, women frequently earn less than men in the same job. At the community level, men may tend to have formal leadership roles and perform high-status tasks while women often do the organizing and support work.

Because women are active in all three types of labor (reproductive, productive, and community), they are said to have a "triple role." Productive work is recognized and valued, while reproductive work (performed primarily inside the house) is not. Women are often overburdened because they are expected to engage in productive and community work in addition to their reproductive work.

- *Productive*—the production of goods and services for income, trade, or subsistence; tasks that contribute economically to the household and community. Includes wage-earning, crop and livestock production, handicraft production, marketing, fishing, manufacturing, and construction.
- *Reproductive*—the care and maintenance of human life within the household. Includes childcare, food preparation, collection of water and firewood, cleaning, washing, building and maintaining shelter, and health care.
- *Community*—maintenance and improvement of the community as a whole. Includes building schools or clinics, planning celebrations, judging disputes, making laws, and advocating for community needs, such as access to water.

Gender needs—practical and strategic

Practical needs are linked to women's condition. Women's condition refers to women's material state—their immediate sphere of experience. If you ask a woman to describe her life, most likely she will describe her condition: the kind of work she does, the needs she sees for herself and her children (clean water, food, education), where she lives, etc.

Practical needs refer to the requirements for daily living such as water, commodities, sanitation services, and housing. People do not have to be told of these needs—they usually identify them themselves because they are so urgent and critical. Women may identify practical needs related to food and water, the health and education of their children, and increased income. A community in which women must carry water long distances from a river has a practical need for a well. Meeting such needs through development activities can be a relatively short-term process involving inputs such as equipment, (hand pumps, clinics, a credit scheme), technical expertise, and training.

Practical needs can usually be met without changing the social position (status) of the affected population. People's living conditions may improve, but little is done to improve their position and status in society. Projects that aim to meet practical needs and improve living conditions generally preserve and reinforce traditional relations between men and women.

- Tend to be immediate and short-term.
- Are unique to particular women.
- Involve women as beneficiaries rather than active participants.
- Relate to the conditions of daily life—food, housing, income, health care, welfare benefits, etc.
- Are easily identifiable by women.
- Can be addressed by specific material inputs: food, health care services, training etc.
- Can generally be addressed without changing traditional gender roles and relationships.

Strategic needs for women arise from their subordinate (disadvantaged) status and position in society. Position refers to women's social and economic standing relative to men. It is measured, for example, by male/female disparities in wages and employment opportunities, participation in legislative bodies, vulnerability to poverty and violence, and so on.

Strategic interests are long-term and related to improving people's position. These include actions to increase people's knowledge and skills, give them legal protection, and bring about equal opportunities among different social groups. Access to participatory democratic processes is in the strategic interests of the poor in general. Gender equality is in the strategic interest of women in particular. Empowering women to have more opportunities, greater access to resources, and equal participation with men in decision-making is in the long-term strategic interest of the majority of the world's men and women.

- Tend to be long-term.
- Are common to almost all women.
- Involve women as agents, or enable women to become agents.
- Relate to women's disadvantaged position in society, subordination, lack of resources and education, vulnerability to poverty and violence.
- Are not easily identified by women.
- Can be addressed by gender sensitization and consciousness raising, increasing women's self esteem and self-confidence, education and skill training, political mobilization, and empowerment.
- Can empower women and transform gender relationships

Gender throughout Women's Lives

Despite women's biological advantage, their mortality and morbidity rates frequently exceed those of men, particularly during childhood and the reproductive years. Female children age 1-4 have higher mortality rates than boys in 17 of the world's poorest countries, due to the parents' bias toward boys, who often receive the best food and medical care. Program efforts also need to focus on balancing this gender inequality so all children receive the love, care and support they need to grow into healthy, compassionate adults.

Early childbearing has life-long health, social, and economic consequences for girls, limiting their educational and employment opportunities and making it more likely that they and their children will be poor. Inadequate information and education about sexuality and family planning, a perception of limited life options, and lack of equality in sexual relationships contribute to early sexual activity and unplanned pregnancy. Socio-cultural norms in Afghanistan prevent women from being seen by a male healthcare provider, if she is given no other option, she may choose not to seek care at all. .

Unequal sexual relationships contribute to women's greater risk of contracting HIV/AIDS. On average, women become infected with HIV five to ten years earlier than men. Social norms that

require female passivity and economic dependence on men make it difficult for women to insist on mutual fidelity or condom use. Similarly, social norms contribute to violence against women, including rape, domestic violence, murder, and sexual abuse. Women victims of violence rarely receive legal protection, rehabilitative care, or compensation.

Education at all levels for females lags behind that for males. Afghanistan now has "the worst education system in the world," and one of the lowest adult literacy rates, at just 28.7 per cent of the population. In some provinces, over 61 per cent of children are not enrolled, and over 80 per cent of girls do not attend school. Despite recent progress in raising educational enrollment rates, gender inequality persists due to cultural factors, household responsibilities, early marriage, and pregnancy. While boys are expected to remain in school to become primary wage-earners, girls are thought either not to need education at all or to need less education to be wives and mothers and are removed from school to perform domestic and wage labor. Nearly 80 per cent of the country's 6,900 schools were damaged or destroyed in fighting. The lack of appropriate educational facilities such as separate classrooms, same-sex teachers, and neighborhood schools also affects the likelihood that girls will go to school.

Of the 1.2 billion people living in poverty in the world, 70 percent are women. Women's poverty is directly related to the absence of economic opportunities and resources, including credit, land ownership, and inheritance, as well as minimal participation in the decision-making process. Although women do two-thirds of the world's work, they own less than 1 percent of the world's property.

Improving Gender Equity

Equity in health aims to increase fairness and justice for both sexes thus reducing unfairness or disadvantage in the provision of health services. To realize gender equity, women need to be empowered to have joint decision-making power with their male partners, which will benefit the well-being of the family members including that of women themselves. Most development specialists agree that sustainable development is not possible without the full participation of both halves, female and male, of the world's population.

Development policies that incorporate gender as a factor reflect a growing understanding of the necessity for women's and men's full and equal participation in civil, cultural, economic, political, and social life.

Gender-focused development means that female and male infants are given equal opportunities to survive, boys and girls are equally nourished and educated, and women and men have equal opportunities to contribute to and benefit from social, economic, and political processes. With equity, women and men will enjoy full and equal legal rights and access to and control over resources. Together, women and men can participate in building more equitable, secure, and sustainable societies.

> *Equality between women and men is a matter of human rights and a condition for social justice and is also a necessary and fundamental prerequisite for equality, development and peace. A transformed partnership based on equality between women and men is a condition for people-centered sustainable development.*

The Fourth World Conference on Women, 1995

Annex A3

Gender Awareness Trainers' Guide

Introduction to training
The goal of this session on gender is to increase awareness among doctors, nurses, and midwives about the issues related to cultural expectations of gender roles and how they impact on health and delivery of health care services.

This workshop session is designed to give providers a chance to "bring alive" the gender issues that permeate all cultures in order to become more sensitive to the impact of gender in health service delivery. It is hoped this training will serve as a first step in catalyzing the awareness necessary to work for change and greater gender equity; to make a better world possible for men and women.

Objectives

- Define the meaning of gender.
- Describe gender issues that effect health in your community.
- List several gender stereotypes in your culture.
- Explain possible options for addressing gender inequities in health care service delivery.
- Demonstrate the practice of gender sensitivity during health care delivery.

Organization of the Training
There are 4 exercises, plus the introductory discussion, in the training. Trainers should be equipped with a flipchart and marker pens. Each session has learning objectives, exercises (brainstorming, cases, or exercises) and approximate time length. The sessions are interactive and comprise realistic exercises that provide opportunities for gender awareness to develop. Answers to discussion questions are meant to be possible answers, not necessarily the only answers, or the correct answers, but serve to help trainers with discussion.

It is important that the trainers take the time to carefully read the reference manual and review the trainer's manual ahead of time. The trainer should be very familiar with this information before starting the day of training.

Session content
Introductory discussion (30 minutes)
Brainstorming about gender roles and stereotypes (60 minutes)
Case study: A girl's life (60 minutes)
Group work: Identify gender issues seen in the health facility and the community and find solutions. (30 minutes)
Brainstorming exercise: the ideal world: no gender inequality (30 minutes)

Gender awareness exercises

A. Brainstorming about gender roles and stereotypes *(60 minutes)*

Objective: Realize and overcome gender stereotypes and understand their meaning
Procedure: brainstorm the following activities with the whole class. Write answers on the flipchart.

2. Write the following two phrases, "In my culture, women must… In my culture, men must …." one per flipchart page. Ask the participants to respond and write the responses under the phrases.

- Discuss the activity using the following questions:
  - What are your observations in comparing these two lists? What do these lists show you?
  - How do people view the characteristics/activities on the two lists?
  - Do women and men have to be or do the things that you wrote down?
  - Can women and men do things expected of the opposite sex? What are the consequences?
  - How do these different roles, responsibilities, and expectations affect the life choices of women? Of men?

- *Emphasize that both women and men are restricted in their behaviors, responsibilities, and life choices because of culturally assigned roles and stereotypes.*

2. Present the definitions of sex roles and gender roles. Sex and gender roles are activities assigned to individuals based on either sex (biological characteristics) or gender (socially determined characteristics). Ask the participants if they can think of examples of male and female gender roles from their experience. Write their responses on the flipchart.

- *For example: women cook and clean the house; men earn income through paying jobs outside of the home; In one study of 224 cultures, there were five in which men did all the cooking and 36 in which women did all the house building.*

3. Present the issue of gender stereotypes: they emerge from confusion between sex roles and gender roles. When it is believed that gender roles are based on biological differences rather than socially constructed expectations, the result is gender stereotypes. Ask participants to share examples of gender stereotypes. Write their responses on the flipchart.

Below are lists of common female and male gender stereotypes.

Women are:	***Men are:***
• *Dependent*	• *Independent*
• *Weak*	• *Powerful*
• *Incompetent*	• *Competent*
• *Less important*	• *More important*
• *Emotional*	• *Logical*
• *Implementers*	• *Decision-makers*
• *Housekeepers*	• *Breadwinners*
• *Supporters*	• *Leaders*
• *Fragile*	• *Protectors*
• *Fickle*	• *Consistent*
• *Fearful*	• *Brave*
• *Peace-makers*	• *Aggressive*
• *Cautious*	• *Adventurous*

• *Flexible*	• *Focused*
• *Warm*	• *Self-reliant*
• *Passive*	• *Active*
• *Followers*	• *Leaders*
• *Spectators*	• *Doers*
• *Modest*	• *Ambitious*
• *Subjective*	• *Objective*
• *Soft-spoken*	• *Out-spoken*
• *Secretaries*	• *Bosses*
• *Nurturing*	• *Assertive*
• *Gentle*	• *Strong*
• *Excitable*	• *Stoic*
• *Patient*	• *Impetuous*
• *Cheerful*	• *Forceful*
• *Caretakers*	• *Achievers*
• *Cooperative*	• *Competitive*

4. Discuss the meaning of gender discrimination: the unequal or unfair treatment of men or women based solely on their sex rather than on their individual skills, talents, and capabilities. (This concept can be explained by comparing it to racial discrimination, which is more widely understood).

Ask participants to identify whether each statement demonstrates a gender role, gender stereotype, sex role, or gender discrimination. Remind participants that gender roles (roles that are socially constructed) are often believed to be biological and thus unchangeable. In fact, the only items among the statements that cannot change are those related to sex roles.

Note to the trainer: The distinction between gender roles and gender stereotypes is not always clear. Gender roles are usually based on gender stereotyping; for example, the belief that nursing is an occupation for women is based on the gender stereotype that women are caring and nurturing by nature but that they are not good enough in science to become physicians. When discussing these items, focus less on the distinction between gender roles and gender stereotypes and probe instead for the reasons the activity is assigned to a particular sex. Reinforce that the reasons usually relate to gender stereotypes.

Statements about men and women:
1. Women give birth to babies, men do not. *(sex difference)*
2. Girls are gentle, and boys are tough. *(gender stereotype/gender role)*
3. Amongst Indian agricultural workers, women are paid 40-60 percent of the male wage. *(gender discrimination*)
4.. Women can breastfeed babies; men can bottle-feed babies. *(sex difference)*
5. Most building site workers in Britain are men. *(gender role, possibly gender discrimination)*
6. Men are better than women at math, physics, and science. *(gender stereotype)*
7. In Ancient Egypt men stayed at home and did weaving while women handled family business. Women inherited property and men did not. *(gender roles)*
8. According to UN statistics women do 67 percent of the world's work, but their earnings amount to only 10 percent of the world's income. *(gender discrimination)*
9.. Men's voices break at puberty, women's voices do not. *(sex difference)*
11. Women are soft-spoken and gentle; men are assertive and strong. (*gender stereotypes*)
12. Men make decisions about family planning and the number of children a couple will have. *(gender role/gender discrimination)*

B. CASE STUDY: A GIRL'S LIFE *(60 minutes)*

Objective: Understand the meaning of gender especially in the context of health
Procedure: Divide participants into small groups. Ask a volunteer in each group to read aloud the case study. Have participants brainstorm the questions below in their small groups. A volunteer should take notes and summarize the answers. After all the questions have been answered the groups will share their answers with the whole group. List the answers on the flipchart.

Shafiqa was born into a family of six children—four boys and two girls. She was the fourth child and the youngest girl. Her family survived by farming and selling a small amount of cash crops. Often there was not enough food to feed everybody in the family adequately. As in most families in her community, her father and brothers ate first, then she and her sister were fed, and her mother ate last. Shafiqa grew slowly, but this was considered normal.

When she was six, Shafiqa began school. But after two years, she had to stop because there wasn't enough money to send all the children to school. Her two older brothers continued, while Shafiqa and her older sister stayed home to help their mother with farming, caring for their young brothers, and other household tasks.

By the time Shafiqa was 12, the family was better off financially. They'd learned some new agricultural techniques and were selling more crops. Shafiqa wanted to return to school, but her father would not let her. The school was far away, and he was concerned about her traveling that distance. Also, there was only one male teacher at the school, and he did not find it appropriate that his daughter, who was nearing puberty, be taught by men. Besides, he explained to his wife, Shafiqa would be getting married soon—there was no need for her to go to school, and no need to risk her being spoiled before marriage. Her older sister, Suraya, who was 17, had already been married two years and had one child.

When Shafiqa was 15 she was married to Ahmad and went to live with his family. Within four months she was pregnant. By the time she was 18, she had three daughters. She was always tired, her health was poor, and she often felt isolated and depressed. Though she couldn't read, she had heard about family planning and suggested to Ahmad that they consider it so she could have a rest. Ahmad became furious and beat her. He pointed out that she had not yet provided him with a son and that family planning was unnatural, anyway. Shafiqa, feeling that she had been appropriately reprimanded for her bold and presumptuous behavior, did not bring up the subject again.

Shafiqa's health continued to deteriorate. She was treated several times at the health clinic for itchiness and discharge in her genital area. Each time, the nurses at the clinic told her that she must use condoms to prevent this sickness. They would become quite annoyed that she had not used them. But Shafiqa knew that Ahmad would refuse them. Shafiqa's fourth child was a son, and Ahmad was very pleased. He looked forward to his second and third son. Meanwhile, Shafiqa became more and more sad and tired.

1. Identify the factors that contributed to Shafiqa's poor state of physical and emotional health. Be sure to think about the cultural, social, economic, and political factors that affected Shafiqa throughout her life cycle.

- *Possible factors:*
  - *poor nutrition in early years*
  - *lack of access to education because of gender discrimination;*

- *expected role of girls and women; cultural tradition of early marriage;*
- *illiteracy;*
- *role of husband as decision-maker;*
- *preference for sons;*
- *poor health education and support from the health center;*
- *lack of involvement and responsibility of husband for reproductive health of his wife, etc.*

2. Develop a list of different program interventions that could have been introduced at various points in Shafiqa's life that might have improved her reproductive health.

- *Possible programs*
  - *Free village schools with male and female teachers.*
  - *Adult literacy program*
  - *Health education from CHWs in the community about maternal health and birth spacing – to include men and women*
  - *Better health services for women: family planning (promotion and availability of methods), iron supplementation.*

3. **Practical and strategic needs:** Discuss with the class the concept of practical and strategic needs and identify examples of projects that address practical needs and projects that address strategic needs to ensure that participants understand the distinction.

:

- *Practical needs: projects that address such immediate needs as health, family planning, housing, water supply, sanitation.*

- *Strategic needs: projects such as legislation for equal rights and opportunities for women, eliminating harmful traditional practices and violence against women, increasing women's participation in decision making, literacy, education, etc.*

3a. Divide participants into four groups. Ask two of the groups to identify the practical needs of Shafiqa and the types of projects that might address these practical needs. Ask the other two groups to identify Shafiqa's strategic needs and the types of projects that might address Shafiqa's strategic needs. Allow each of the groups to present their findings and list them on the flipchart.

Practical needs: better nutrition for young girls, general education, health education, health car, family planning

Possible projects: health education about the issue of girls health influence later health during child bearing, village schools, CHW programs for community health education, promotion of birth spacing with the community and the health facilities, have a variety of methods free and available with female health providers well–trained about methods, including IUD insertion.

Strategic needs: to have a greater role as decision maker in her personal health and within the family, to value females and males equally,education.

Possible projects: Community leadership positions filled by both females and males, promote the equal education of boys and girls, promote adult literacy programs, focus groups addressing gender issues

3b. In the large group, refer to the list of Shafiqa's practical needs and strategic needs. With the whole group, discuss the relationship between them.

- Which needs are most immediate? *Practical needs*
- Which strategic needs are most essential for women's empowerment that results in real change in status and position?

Their responses should acknowledge that addressing strategic gender needs often results in changes in power relationships and issues of control—control over decision-making about income, household resources, fertility, and other key issues. Point out that it is not always easy to determine whether an activity is meeting a practical gender need or a strategic gender interest; sometimes it can do both.

Note: it is not necessarily "better" to address strategic interests rather than practical needs. Because the inequities between men and women can be so great, in some situations it is essential to address women's practical needs before it is possible to address their longer-term strategic interests. For sustainable empowerment of women to occur, however, programs that meet women's strategic interests must eventually be developed.

- If the interventions implemented affected only Shafiqa's practical needs but not her strategic needs, what do you think the outcome would be for her? Would her life be different? In what ways? What about her children's lives?

Emphasize that it is not wrong for a project to address only practical gender needs. Practical needs usually must be met before strategic interests can be addressed. In some communities, meeting a practical need may serve as an entrée to addressing a more strategic issue; in other settings, an organization may determine that taking on strategic issues is not feasible.

- Why is it important to consider strategic gender issues?

  In order to implement effective and sustainable programs it is often necessary to consider strategic issues—issues of power, control, and status—because they can serve as obstacles to the attainment of reproductive health. Addressing strategic issues enables us to get at the underlying structures that perpetuate the problem.

C. Group work: Identify gender issues seen in the health facility and the community and find solutions. *(30 minutes)*

Objective: Demonstrate the gender sensitive service delivery in their practical work
Procedure: Divide participants into small groups. Have participants identify gender issues in their own health facilities, and in their communities in way that impact health. List them. Then they should propose realistic solutions to change the situations. A volunteer should take notes and summarize the answers. The groups will share the identified gender issues and possible solutions with the whole group.

D. Brainstorming exercise: the ideal world: no gender inequality *(30 minutes)*

Objective: Use their new gender awareness to demonstrate/list what is possible.
Procedure: Refer back to the flipchart in the first exercise, where participants explored gender roles and expectations and completed the sentence, "In my culture, men (women) must . . . ."

Remind participants that gender differences are socially constructed and learned. Ask them to close their eyes for a minute and try to imagine a world where gender inequalities no longer exist—where men and women have the same rights; the same possibilities for education,

employment, and advancement; the same income-generating power; and the same decision-making power.

Divide participants into small groups and have them answer the following questions. One participant should summarize the answers and share in the large group afterward.

- What would that world be like?
- What would the impact of such gender equity and equality be on the reproductive health of that society?
- How would the reproductive health roles and responsibilities within the family shift? What would those roles be like?
- Who would benefit?
- Identify ways in which the promotion of gender equity can result in positive gains for men as well as women.
- Develop strategies and approaches for involving men in reproductive health programs and promoting changes in traditional gender roles.

Annex B2

Gender Awareness Training Workshop

Date: 7-9 March 2005
Place: REACH Field Office, Herat
Participants: Herat PPHCC members

Background:

The March 7-9 Gender Awareness Training Workshop in Herat was the second in a series of gender awareness workshops being held by the REACH Gender Unit. Considered by many to be a city of educated and cultured people of both sexes, Herat could be expected to have people who understand and discuss gender problems and express their ideas openly.

MOWA had already held gender awareness training and gender and development training in Herat for participants from governmental and nongovernmental organizations. After coordination with MOWA, the REACH Gender Unit decided to conduct its Gender Awareness Workshop for Herat PPHCC members, all of whom are managers in the Provincial Public Health Office, REACH grantee NGOs, or other governmental and non-governmental organizations working in the health sector.

Twenty-two people (8 women and 13 men) participated in the workshop (see Annex 1). Some women expected to participate, including Drs. Raufa Niazi, the Provincial Public Health Director, and representatives from the Women's Affairs office in Herat, were unable to attend the training because International Women's Day fell on the second day of the workshop, .

Highlights of the Training Agenda (see Annex 2)

- **Definition of "gender":**
  Participants strongly disagreed with the internationally accepted definition of gender because it does not reflect Islam, which defines people's behavior in Afghanistan. Although a separate session on Women's Rights in Islam and on Islam and Family Planning was planned, participants wanted a clear explanation of "gender" and its relevance to Islam right away.

- **Islam's view on the use of IUDs**
  Sessions on women's rights in Islam and Islam and family planning were the most controversial. One female doctor told of a gynecologist at her workplace who had never used an IUD, believing their use to be prohibited by Islam. While some participants also agreed with this view, the facilitator found a logical answer and was able to convince the group that Islam does not forbid use of an IUD.

- **Violence against women in Herat:**
  Women in Herat have difficulties with the process of divorce and other family related problems. Many lack freedom and are unaware of their rights, a situation also noted among the workshop participants, including female health professionals.

- **Recommendation from the participant**s:
  Most participants agreed that the women of Afghanistan have problems. They promised to hold similar workshops in their workplaces if REACH will supply the materials. The participants said they would first work toward establishing gender equality in their work-places and then look for other opportunities for these kinds of activities.

Lessons learned from this workshop:

- The definition of gender should not be introduced in the beginning of the workshop but instead toward the end of the day so that people will be aware of its socio-cultural context.
- The sessions on Women's Rights and Islam and Islam and Family Planning need to be more oriented toward increasing awareness rather than being dogmatic or focusing on quotations.
- A dialogue with influential and open-minded religious leader(s) may be useful to defend the points in the presentation
- Training methods should include use of an LCD projector.
- Both female and male trainers are necessary.

Conclusion:

Although some participants (both male and female) did not agree with all that was said on the training topics, in general, they were actively engaged in the discussion.

Most female participants in the workshop had had a variety of family problems caused by gender inequality and illogical customs in the Herat area. The facilitators were able to discuss and clarify the main cause of these problems.

At the end of the workshop, participants agreed to observe gender equality and equity in their workplace and family life; in addition, they requested the necessary materials and economic help to promote gender equality and equity in their community. Some participants were convinced that potential backlash will make it too difficult to adjust unequal gender relations in Afghan society during the near future, but parallel with other cultural progress, they will gradually promote gender awareness in their community.

Annex 1

List of participants

No	Name	Position	Organization	M/F
1	Pari Gul	Field Officer	N P O	F
2	Dr. Bashir Ahmad	Health supervisor	N PO	M
3	Ms. Mariam Ahmadi	Assistant of Provincial Health Officer	C H A	F
4	Ms. Shaima	Program Officer	I R C	F
5	Hemat Ullah	Health educator	I R C	M
6	Dr. Rasool	N T C	W H O	M
7	Ms. Jamila Rahmani	Midwife		F
8	Dr. Naeema	STI Officer	W V I	F
9	Dr. Elyar	Medical coordinator	M DM	
10	Dr. Abdul Rahim (Abid)	Master Trainer	W V I	M
11	Dr. Ahmad Shah Ahmadi	Provincial Health Officer	CHA	M
12	Dr. Zarif Ahmad	HMIS Officer	MSH	M
13	Dr. Aziza	Health Officer	A R C S	F
14	Dr. Shokori	Health Officer	Internal world	M
15	Ms. Lailoma	Nurse		F
16	Dr Shakila	Gynecologist	MOPH	F
17	M. Daud	Log / ass		M
18	Dr. Matin	Master Trainer	HCP	M
19	Dr. Ahmad Shkib Safi	Health Advisor	COAR	M
20	Dr. Abdul Qadeer	Laboratory officer	MOPH	M
21	Dr. Ghulam Rashed	Provincial Health Advisor	MSH	M
22	Asif Obaidee	Adiministrative/Finance Officer	MSH	M

Annex 2

Schedule:

Time	**DAY 1**	**DAY 2**	**DAY 3**
9:00 – 9:30	• Recitation of Holy Koran • Introductions • Objectives	• Review of DAY 1	• Review of DAY 2
9:30- 10:30	• Gender and Sex	• Gender Issues and Needs	• Women's rights in Islam
10:30 – 10:45	Tea break		
10:45 – 12:00	• Characteristics of being male and female	• Gender needs for Afghan men and women; solutions	• Islam and Family Planning
12:00 – 1:00	Lunch and prayer break		
1:00 – 2:30	• Gender roles • Women's triple roles	• Gender Gap • Gender discrimination, oppression	• Next steps
2:30 – 2:45	Tea break		• Evaluation
2:45 – 3:30	• Reproductive Health	• Violence against women • Showing film on stoning	• Distribution of certificates • Closing remarks
3:30 – 4:00	Summary of DAY 1	Summary of DAY 2	

Annex B3

Paktya Gender Awareness Training Report

Date: 18 to 20 April, 2005
Place: REACH Field Office, Paktya province
Participants: 30 PPHCC members
Date of report submission: the giving report: 1 May 2005

Background:
Paktya province is located in southeastern south east zone of Afghanistan; most of the population work in agriculture or in various vocations in the bazaar. as most of the people are busy with agriculture and or working as different vocational workers in the free bazaar In this province, a variety of different problems have been seen within among the family, schools and workplaces. For example, both governmental and non-governmental organizations have a the shortage of female staff. Due to traditional customs, the marriages of the is felt in the governmental and nongovernmental organizations. Mmajority of adults and youths, both male and female, are not arranged including girls and boys according to their wishes. Men ignore the overwork of women The overworking of women is ignored by men in the workplace and households.

Purpose:
Tmembers of Paktya. The main aim of workshop was o introduce managers in the Paktya health sector to the concept of gender among the managers of Paktya Health Sector so that they can act as catalysts in the removal of barriers to gender equity from in this geographic area. The workshop was designed to enable PPHCC members to do the following:

1) Understand the meaning of gender,
2) Recognize and overcome gender stereotypes
3) Integrate gender into Provincial Health activities

Thirty staff from the provincial MOPH and, MOWA, and REACH NGO grantees (IMC Khost) manager) and from other oOrganizations working in Paktya's health sector participated in the workshop (8 women and 20 men). The total of participated in the workshop (See Aannex 1.)

Introduction:
A three-day workshop for the members of Provincial Health Coordination Committee.

Methodology:
Group work, presentation, brainstorming, role play, showing of the motivational Afghan film named "*Sangsar*" , and discussion

Highlights of the Training Agenda:

- **Shura composition in Paktya**
  In Paktya, separate Shuras exist for men and women. All projects proposed by the male Shura must be approved by the members of the female Shura. Thus women have the opportunity to participate and make decisions.

Suggestions:
- The workshop agenda scheduled a session on women's rights in Islam for the third day. It would be a good idea to invite a popular mullah from the area to help in discussing women's rights in Islam and family planning in Islam

- Women should be encouraged to participate in the workshops; if only a small number of female managers are available, midwives and female doctors can be invited.

Conclusion:
All participants remained actively engaged throughout the workshop. Most had a good attitude toward women's rights in Islam and were broad minded. They were familiar with the rights of women in Islam and were convinced that progress requires the participation of women in every aspect of life. Participants felt that it would be difficult for them to change customs in a short time; they decided to observe gender equality and equity in their own workplace and to convey the message through channels available to them as soon as possible.

Annex 1
List of participants

NO	Name	Title	Organization	Tel. no	Email Address
1	Dr. Hayatuddin	Supervisor	S C A	79293502	healthsro@ eikmail.com
2	Dr. Saleh Moh'd	Master Trainer Supervisor	Ibn Sina	79147614	
3	Dr. Said Amir	Orthopaedic surgeon	Ibn Sina	79405711	
4	M.Omar	Engineer	N P O	79236872	
5	Rohullah Moh'd		Ibn Sina	79032273	rohullahmohammad@yahoo,com
6	Khan Zad Gul Ahmad Zai	P T C	M O P H	79374257	
7	Dr. Sharifullah	Sub.Nation O M & E officer	G F M U	79135714	drsharif@yahoo.com
8	Dr. Fazal Karim	Dctor	W A D A N	79436113	fazalkarim74@hof
9	S.Fazal Shah	Admin Officer	C A R E	79136379	
10	Aqlimah	F C F	C A R E		
11	Mahmood Khorram	C S A comunity servive Assistant	UNHCR	79111404	khorram@unhcr.ch
12	S.Daud	AIHRC	AIHCR	79342115	079342115 Gardez
13	Shazia		Hospital		
14	Shafiqa		Hospital		
15	Gul Rahman	Administrative / Financial Officer	MSH	79237432	gulrahman@msh.org
16	Dr. Khaled	H. Officer	REACH	79105655	Khaled-aryanfar@yahoo.com
17	Dr. Nazar.M	P.H.O	MOPH	79282130	
18	Dr. Allah Dad	Technical Manager	I M C paktika	79105630	marufkhil@yahoo.com
19	Dr.Sher.M	IMC Manager	MOPH	79235937	
20	Dr. M. Sharif	P.N.O	M.O.P.H paktika	79409871	
21	Habib.M	PEMT Manager	POPH	79310786	
22	Dr.A.Hakim 'Asas'	Project Officer	I R C	79311852	
23	Dr. Zahra	Reproductive Health Officer	MOH		
24	Dr. Farahnaz	Master Trainer Supervisor	MOH IRC		
25	Ms. Gul Makij	Student M.W	IRC		
26	Ms. Fatema	Student M.W	IRC		
27	Ms. Halima	S.W	Women's D.W.N		
28	Ms. Shafiqa	Student Midwife	I.R.C		
29	Ms. Shafiqa	Hospital			
30	Dr.S.Ghulam Sakhi	Deputy Director	MOH		
31	Dr.Faqir.M Khaled Yar	PPO WHO	WHO		

Annex 2

REACH GENDER UNIT FIELD VISIT REPORT: PAKTYA

Prepared by: Dr. Rahila Juya, National Gender Officer

Sunday, 17 April 2005		
OBJECTIVES OF THE VISIT	• **To be aware of gender issues in Paktya province** • **To meet individuals to learn the status of and issues concerning women in Paktya** • **To visit a female CHW supported by REACH and informally discuss her responsibilities**	
People met	**Key findings**	**Remarks**
Ms. Halima Khazan Director of Women's Affairs in Paktya	• Halima Khazan High School, Gardiz City, was built with Ms. Khazan's help. Two thousand girls are enrolled and studying; a small group of boys also attends the school. Ms. Khazan teaches Pashto at the school as a volunteer. • Halima Khazan H S has had a center for English and computer training since 2003, but because there is no female instructor, the center is not active. • Eighteen girls have graduated from Halima Khazan HS and are soon to take the University entrance examination. Khatera is the most intelligent girl in the province; she will take the entrance examination this year • Two faculties are active in Paktya; agriculture and literature • On Women's Day (8 March), the provincial MOWA directly invited 200 women to attend the ceremony; 500 women attended. • Halima Khazan has successfully contracted 30,000 square meters of land for a women's garden. • Women's affairs has taken 40,000 square meters of land for use by displaced women. • Halima Khazan does not permit students to use mobile phones during class. Ms. Khazan will break the phone of any student violating the rule in front of his/her parents. • Eleven women from different districts of Paktya have joined the police department as police officers. Ms. Khazan believes these women should not wear on official uniform because it will pose a security risk; all necessary precautions should be taken for them. In general, it is proper, and a priority, for these women to continue permanently in their jobs. • Many men, including small boys, are addicted to heroin.	The visit was made while school was in session; pictures of the students at their studies were taken in the classroom.

Mr. Said Daud Sah Sameen, Children's Rights Officer at Afghanistan Independent Human Rights Commission, Paktya office	• The Human Rights Commission organized a workshop about children's rights in Khost; 30 people (7 women and 22 men) participated. • Three workshops on women's and children's rights were conducted in various places in Paktya. • Thirty-one women participated in other workshops on women's rights held in Khost.	AIHRC is financially supported by UNDP. Female authorities went for vocation in Khost
Mr. Said Fazal shah Admin finance officer of CARE	• Since 1993, CARE has had projects called COPE, "Solar 1" and "Solar 2." Solar 2 is focused on water supply and sanitation; the COPE project is working to support schools. The community has requested an increase in the number of schools; schools that go to a higher grade level will be built. • NSP is active in the districts of Ahmad Khil ,Said Karam ,AhmadAgha, Shoak and Zormat. A new program has begun in Ahmad Khail and JaJi as well. • After selecting a place to establish a Shura, the next step will be to have the community choose the head of the Shura and its members. A separate Shura for men and one for women will be selected first. The plan is also to create a mixed Shura (both men and women) in the near future. • Initially, the community did not even agree to create a male Shura, but a short while after they did, they also agreed to create a separate Shura for women. The female Shura must agree to and provide its signatures before any project, including building projects, can be finally approved.	Eng. Hassan Khan Ahmad Zai, manager of care was not present to speak with him
Ms. Shahzea, Midwife at Paktya Hospital	• Ms. Shahzea comes from a district of Paktya. She has three daughters. She works at home and in the hospital and is on duty two days a week.	

Dr. Faranaze, midwife trainer	• Dr. Faranaze said that the women living in the city, even those with conjunctivitis or heart problems that need to be checked by a specialist, are only be taken to a female doctor by their husbands. The men repeatedly insist on taking them only to female doctors, regardless of their conditions. • According to Dr. Faranaze, the women in the province are generally depressed due to a variety of problems. One woman visiting her in the private clinic where she works (see remarks) told Dr. F. that she was depressed by her husband's drug abuse; he comes home late every night and uses heroin in front of their children. • The second phase of IRC community midwifery training is on-going. One IRC trainee has dropped out of the training program. Dr. F. did not know why. The others are attending class regularly.	Dr. Faranaze is the IRC Midwifery trainer; she works in both the hospital and a private clinic.
Visit to migrant camp	• Nearly 400 families live in this camp. All are from Paktya and during the war were out of country. All needed facilities are provided for them. They have comfortable housing and a water supply as well as a newly built clinic.	The clinic for the camp was established with the help of IRC.

Annex 3: A Story of Layla in Gardez city (This story is true, but all the names in have been changed)

Layla was 18 years old and from a rich family. Her father, Qader Khan, is a wealthy and prestigious man in the area.

Layla loved Jalaludden, and her mother knew it.

Nevertheless, Layla was engaged to one of her relatives. Layla did not like the person who was chosen and continued to communicate with Jalaludden for nearly 8 months. One day she decided to escape from the house and made a plan with Jalaluden to go somewhere else. They succeeded in carrying out their plan.

When Layla's father heard that his daughter had escaped from the house, he punished his wife, saying, "You have known about their communication with each other! Why didn't you keep me informed?"

Qader Khan searched everywhere for his daughter for one week; then he heard from a relative that his daughter was living in a district of Paktya.

Do you know what happened to Layla when she went with her favorite, Jalaludden?
I know that your guess is not correct, because after leaving home, Layla was sexually abused by six men who were friends of Jalaludden.

Now she still lives with her relative in one of the districts of Paktya

When Qader Khan obtained evidence of what happened, he was very angry and he ordered Jalaludden's father to bring 400,000 Afghanis, one unmarried girl, one married woman and four sheep. If Jalaudden's father does not comply, he and his family will face many problems and should expect a very terrible incident.

Annex D

REACH Initiatives to Support Women

The USAID-funded REACH Program aims to improve the health of women of reproductive age and children under age five through the increased use of basic health services in rural areas. To have the greatest impact over a three-year period (May 2003 – May 2006), the REACH Program technically supports 19 Afghan and international NGO grant recipients delivering the Basic Package of Health Services (BPHS) in 13 USAID priority provinces.

Major accomplishments of the initiatives to support women are listed according to REACH Intermediate Results (IR).

Under IR 1: Expanded access to quality BPHS services

- A REACH grants program has issued $67 million in grants to Afghan and international NGOs to deliver the BPHS, which emphasizes maternal and child health and family planning, and for the training of community and hospital midwives. The REACH Program currently provides access to health care to nearly 2 million women of reproductive age in 14 Afghan provinces.
- As of Jan. 2005, REACH NGO grantees have trained 2,400 Community Health Workers, 1,158 of them female; 49 midwives have graduated from the Institute of Health Sciences; and over 700 women are enrolled in community and hospital midwifery programs.
- REACH gives priority to female health providers in refresher training courses. To date, women have comprised 41% of the 432 doctors, midwives and nurses who have finished refresher training in one of the following modules: family planning and infectious disease, Integrated Management of Childhood Illness, and newborn care.

Under IR2: Improved capacity of individuals, families, and communities to protect their health

- The REACH Program has distributed approximately 250 sets (one per facility) of Information, Education and Communication (IEC) materials with MOPH approved health messages on malaria, control of diarrhoeal disease, personal hygiene, and birth spacing to all of the 19 USAID-funded NGOs delivering BPHS. These pictorial IEC materials greatly help women in REACH provinces, most of whom are non-literate, to understand messages that can result in healthier behavior.
- Over 1,300 women are enrolled in *Learning for Life*, an accelerated health-focused literacy program designed to increase the literacy rate among women, enable their understanding of health messages, and qualify numbers of women for training as community midwives and midwives.

Under IR3: Strengthened health systems

- The REACH Gender Unit conducted a workshop on "Problem Identification for Empowerment of Women in the Afghan Health Sector" in November 2004 for approximately 60 Afghan women working in the health sector; establishment of the Association for Women Health Professionals is underway to build the capacity of women health professionals and enable them to assume a larger management role in the Afghan health sector.
- The REACH Gender Unit will play an active supporting role in the Gender and Women's Rights Unit to be established within the new MOPH.

Cross-cutting areas

- The Baseline Household Survey conducted by REACH NGO grantees in early 2004 found a contraceptive prevalence rate of 16%; an average of 21% of the women of reproductive age aware of at least two modern methods of contraception; and 12% of women attended by

skilled birth attendants during delivery. An End of Project survey will determine the percentage of progress in these areas.

- The REACH Gender Unit conducts three-day gender awareness workshops for the members of Provincial Health Coordination Committees in 13 REACH provinces (training in two provinces has been completed as of March 2005).
- Three of six REACH Program Managers are women. Afghan women comprise 24% of REACH technical staff; when expatriate female staff are included, the percentage of female technical staff rises to 44%.

Annex E

The percentage of female participation in REACH activities in provinces
Quarterly Consolidated Report from Feb to April 05

S.N	Name of the meeting/ Training/ Workshop	REACH Dept.	Province	Date	No. of female participants	No. of male participants	Total participants	% of female participants
1	PHCC	PSS	Paktya	6-Mar-05	0	11	11	0%
2		TAE	Kabul	26/Feb – 17/March, 05	0	16	16	0%
3	PHCC	PSS	Takhar	12-Apr-05	1	17	18	6%
4	PHCC	PSS	Bamyan	14-Feb-05	1	14	15	7%
5	PHCC	PSS	Faryab	Feb-05	2	27	29	7%
6	PHCC	PSS	Ghazni	2-Mar-05	1	12	13	8%
7	PHCC	PSS	Khost	27-Mar-05	1	12	13	8%
8	HMIS evaluation	PM&E	Kabul	11-May-05	3	25	28	11%
9	PHCC	PSS	Faryab	Mar-05	2	16	18	11%
10	PHCC	PSS	Herat	6-Mar-05	3	19	22	14%
11	PHCC	PSS	Baghlan	2-Mar-05	2	12	14	14%
12	PHCC	PSS	Badakhshan	1-Mar-05	5	21	26	19%
13	Workshop for Developing Community based Training Plan of NGOs	TAE	Kabul	11-12 April 05	11	46	57	19%
14	Hospital Management Improvement Workshop	MoPH-CB	Kabul	13-16, March, 05	7	28	35	20%
15	PHCC	PSS	Badakhshan	23-Apr-05	4	15	19	21%
16	PHCC	PSS	Herat	9-Feb-05	5	17	22	23%
17	Hospital Management Workshop	MoPH-CB	Kabul	24-27, April, 05	9	28	37	24%
18	PHCC	PSS	Badakhshan	9-Feb-05	5	14	19	26%
19	LfL Phase II Grantee Training	TAE	Ghazni, Baghlan, Paktya, Paktika	10-Apr-05	8	20	28	29%
20	Gender awareness training for PHCC members	PM&E	Paktya	18-20Apr,05	10	21	31	32%
21	Refresher TOT for CHW Trainers of NGOs	TAE	Kabul	06-10 Mar 05	5	10	15	33%
22	IP Workshop	TAE	Kabul	13-18 April,05	8	16	24	33%
23	Refresher TOT for CHW Trainers of NGOs	TAE	Bamyan	24-28 Apr 05	6	11	17	35%
24	Managing drug supply and stock managment training of trainers	AQS	Kabul	15-21,Feb, 05	4	7	11	36%
25	Gender awareness training for PHCC members	PM&E	Herat	7-9March,05	8	14	22	36%
26	Refresher TOT for CHW Trainers of NGOs	TAE	Kabul	10-14 Apr 05	9	14	23	39%
27	Orientation to LFL	TAE	Paktiya	17-20, March, 05	2	3	5	40%
28	Refresher training on IMCI	TAE	Kabul, Bamyan,	1-Nov-04 to 19-May-05	151	187	338	45%
29	Refresher training FP/Infectius Disease	TAE	Kabul, Bamyan,	1-Nov-04 to 19-May-07	139	159	298	47%
30	Gender awareness training for PHCC members	PM&E	Bamyan	23-25Feb,05	7	8	15	47%
31	Refresher training on Newborn care	TAE	Kabul, Bamyan, Takhar, Baghlan, Herat, Faryab,	1-Nov-04 to 19-May-06	106	102	208	51%

32	Community Mapping Training to SCUK	TAE	Jawzjan	19-24 Feb, 05	10	9	19	53%
33	TOT for CHW Trainers of NGOs	TAE	Takhar	26-31 Mar 05	10	9	19	53%
34	Community Mapping Training to SCUSA	TAE	Jawzjan	25-28 Feb 2005	11	9	20	55%
35	Accreditation Workshop	TAE	Kabul	17-19 April, 05	24	19	43	56%
36	International Standards for Education in Emergencies	TAE	Kabul	10-Mar-05	2	1	3	67%
37	Refresher training on ANC/PNC	TAE	Kabul, Bamyan, Takhar, Baghlan, Herat, Faryab,	1-Nov-04 to 19-May-08	96	41	137	70%
38	ETS for IP Workshop	TAE	Kabul	28 March – 7 Apr, 05	23	9	32	72%
39	Community Mapping Training to BDF	TAE	Baghlan	13-17 March 05	22	8	30	73%
40	TOT for CHW Trainers of NGOs	TAE	Kabul	20 – 24 Feb 05	17	6	23	74%
41	LfL Gender and Education Training	TAE	Kabul	3-Mar-05	12	4	16	75%
42	Orientation to LFL	TAE	Herat	3-7 April, 05	29	0	29	100%
43	LfL Facilitator Training III	TAE	Kabul	3-7 April, 05	32	0	32	100%
44	Family Planning workshop	TAE	Kabul	30 Apr-10 May,05	16	0	16	100%
							AVG	43%

Annex F

Female Participation in REACH Training / Workshops / Meetings February – April 2005

Data collection method:
The REACH Gender Unit collects the information from each unit of the REACH program at the end of each quarter.

Limitation:
The data and its accuracy is limited to that provided by the REACH unit reporting to the Gender Unit. The number of workshops/training sessions/meetings may not accurately represent all such activities held by REACH during the reporting period.

Purpose:
To monitor the status of women's participation in REACH activities and make recommendations to the relevant unit to improve the participation of women.

Facts:
The Gender Unit collected information on a total of 44 workshops / training sessions / meetings held from February 1 to April 30, 2005.

- Two REACH activities had no female participation (a PPHCC meeting in Paktya and a training session conducted by TAE); however, the number of activities with no female participation is the lowest in all reporting periods since May 2004. Accordingly, the average percentage of women participating in REACH activities is also the highest in all reporting periods since May 2004.
- Despite having had no female participation in a Paktya PPHCC meeting this quarter, female attendance at PPHCC meetings has shown progress, however slight it may be. During the previous report period, many PPHCC meetings had no female participation, but in at least one of those provinces a woman participated in the monthly meeting during the current quarter.
- More women participate in workshops / training /meetings held in the provinces than they do in workshops / training /meetings held in Kabul to which REACH partners from the provinces are invited. Those who come from the provinces to attend are NGO managers, who in the provinces are mostly male.
- The Provincial Gender Awareness Training Workshop, at which REACH requested participants, be an equal number of men and women, did not meet the goal.

Next steps:

- Inform those involved in activities in which no women participated, find out reasons for their non-participation and set goals for the next occasion.
- Inform REACH PHAs of the increased percentage of women participating in PPHCC meetings and encourage them to promote more women's participation in these monthly meetings.
- When a workshop is scheduled, ask REACH departments to facilitate female attendance (i.e., discuss the cost of a *mahram* with workshop organizers, etc.